The coroner does nothing that must not be done over again. No reliance can be placed on anything that he has done, nor can he be trusted to do anything right.—Joseph DuVivier, former Assistant District Attorney for New York County.

The coroner's inquest is scarcely more than a formality.—Editorial, Chicago Daily Tribune, April 5, 1933.

Is it not about time for the office of coroner to be reformed or abolished as both useless and costly?—Editorial, The Chicago Daily News, April 7, 1933.

The repression of crime demands the community's will to repress it. . . . It demands also the reconstruction of antiquated public machinery. — Editorial, The Chicago Daily News, October 25, 1933.

Coroners' inquests, at least in murder cases, are useless and even mischievous. At best they duplicate the work of other law-enforcing agencies—Editorial, The Chicago Daily News, November 1, 1933.

* * *

The official handbook of exhibits in the Division of Basic Sciences in the Hall of Science described the exhibit of the Institute of Medicine of Chicago in the following language.

Institute of Medicine of Chicago

"This exhibit presents an outline of medico-legal facts. The central feature is a diorama which symbolizes the tragedy and enigma of death. This is flanked on each side by two smaller dioramas that portray graphically the four classes into which the death may fall: homicide, suicide, accident, and sudden death. On either side of the diorama unit are painted panels. One is symbolic of the medical examiner system, showing a modern autopsy room with a shrouded body and a gowned figure of a physician ready to begin his examination; in the background are sketches indicative of the scientific procedures that a proper examination must make use of: pathology, bacteriology and serology, chemistry and toxicology, and microscopy. The panel of the opposite side is symbolic of the coroner system. It depicts the usual type of coroner's jury being sworn in for the inquest in the presence of the dead body as the law requires. In the background, corresponding to the scientific procedures in the other panel, are sketches portraying coroner's juries at different periods in history, the object being to illustrate that the office has not changed much since its earliest days. Lettered panels give the essential features of the two systems in use in this country, including such data as origin, mode of selection, tenure of office, qualifications, duplication of other agencies of government, and cost. Diagrams show the organization and relationships within the judicial administrative system of the European medico-legal system with its institute of legal medicine. A similar diagram shows the same features of the two American systems. A few well-selected specimens illustrate some of the features of the different kinds of death that must be officially investigated."

CORRESPONDENCE

Subject of following letter: A communication from the Pacific Roentgen Club concerning an article by Dr. Howard H. Johnson, printed in the September issue of the "Western Hospital Review."

October 15, 1934.

To the Editor:—In the September issue of your journal there appeared an article entitled "Crossroads—Cross Purposes" by Dr. Howard H. Johnson of San Francisco. Since this article proposes changes of a rather radical type in the practice of medicine in the State of California, and since it appears to contain some incorrect or misleading statements, we beg to submit the following for publication:

Fundamentally, the article is a plea for the early establishment of a hospitalization insurance plan in California. One of the main arguments used to support this plea is the alleged success of the plan in Cleveland. One of the major factors in the plan in Cleveland is the provision of x-ray and similar services along with the hospital benefits. We will commence our discussion by commenting on some of the statements in Doctor Johnson's article.

1. On page 6, paragraph 1, Doctor Johnson states that "A plan was then devised by the Academy which would place the 'x-ray . . . men' on exactly the same basis as other . . . professional men practicing in hospital work." This is incorrect and misleading. The actual plan as devised would place the x-ray physician on a totally different status to that of other physicians in the hospital. The radiologist would be prevented from conducting and assuming the responsibility of the examination of the patient himself; a third party, a layman (the technician) hired by and responsible only to the hospital, would be interposed between the physician and the patient. Again, the collection of fees for professional responsibility and opinion would not necessarily be attended to by the radiologist himself; such would only be done if interpretation and consultation had actually been requested by the patient's other physician.

2. In the second paragraph appears the statement, "Academy members were furnished with . . . a statement of those medical men, principally x-ray men, who opposed the plan." This is incorrect. The statement was furnished by physicians in general in Cleveland. It is to be noted that only 266 out of 1,000 Cleveland Academy members, who were circularized, actually voted; of these, only 156 voted for the plan. In the opinion of many, the plan as outlined by the Academy was so ambiguously worded that it may be assumed that even the *15.6 per cent* who voted "Yes" did not fully understand the proposal.

3. In the third paragraph on page 6 appears the statement, "x-ray . . . work of a diagnostic and therapeutic type is thus no longer monopolized. . . ." This is doubly misleading. The major number of hospitals in Cleveland still operate with their radiologists on their former status. In connection with the use of the word "monopoly," it is worth remembering that Doctor Johnson's able friend, Dr. A. C. Christie of Washington, D. C., has repeatedly pointed out that the practice of radiology in the hospital is a form of monopoly *by the nature* of hospital work and not one by choice, and Doctor Johnson is aware that in San Francisco any recognized radiologist is welcome in any hospital x-ray department—the patient need not consult the staff radiologist, except when he so desires. There is no more of a monopoly in the strict sense of the word than actually exists in other departments in the hospital.

4. Doctor Johnson makes the statement that such a plan "will also make it possible to arrange . . . fee schedules on a lower basis." This is very dubious if not actually incorrect. The actual cost of performing radiological procedures has shown no appreciable reduction in the last few years and is probably close to its basic level. Therefore, if the hospital is to recover its costs in the x-ray department, and the physician his reasonable fee for examination, interpretation and consultation, the proposed plan would merely result in the division of the fee into two portions, the total amount of which would be no lower than the present fees. Any further reduction must obviously come from the physician's income.

The responsibility for the examination and treatment of a patient by x-rays is a medical one; such procedures are always dangerous in unskilled hands. Therefore, it would seem unwise for any physician to urge that a lay corporation has the right to assume this responsibility and to regulate the fees that should be charged.

General Comment

The root and source of the whole problem under discussion lie in the desire of the Cleveland Hospital Council to sell, not a group hospitalization plan, but a group hospitalization-with-diagnostic-medical-care plan. Now, the radiologists in Cleveland have always supported and will continue to support any sincere attempt at furnishing hospitalization, or hospitalization and medical care, at reasonable rates upon a reasonable basis. But when laymen or hospitals or any corporation attempt to furnish medical care (*i. e.*, diagnostic x-ray work) along with *and as a part of* hospitalization, then those radiologists, like any other physicians, resent it. They resent it because medical service cannot be properly furnished by laymen; if it were it would lower the status of radiology, and thereby the status of diagnostic and therapeutic care in general. They resent it because physicians and lay-

men alike have pointed out that it would be merely the opening wedge, which could easily result in the inclusion of other types of medical service, until finally lay groups could have complete control of the practice of medicine.

Doctor Johnson implies that the Cleveland plan is working well, that the policies are being sold and that the quality of care afforded the sick patient is not being lowered.

What are the facts? Direct from Cleveland come these answers:

1. The Cleveland Hospital Council has fifteen member hospitals in Cleveland, with a total bed capacity of 3,132 beds. The Cleveland plan is actually operative at present in connection with only 25 per cent of those beds, that is, virtually only with the University Hospital group. The other hospitals, representing *75 per cent* of the Cleveland bed capacity, are at present handling no group hospitalization cases at all.

2. How are the policies being sold? They are being sold with difficulty, the salesman sometimes implying that x-ray service is free. In view of what the patient believes he is getting when he pays for x-ray service, this is obviously not so; however, this allegation is being used and will continue to be used as one of the selling points. Because of this fact alone, one of the directors of the second largest private hospital in Cleveland (the Mount Sinai) has stated emphatically that, as far as he is concerned, Mount Sinai will take no group hospitalization cases. He believes that the plan is being misrepresented to the public.

3. The writer has seen a record of the work done by the University Hospital in Cleveland on a patient recently in there as a "flat-rate diagnostic case." This patient paid $38.50 for a three-day stay in the hospital, having x-ray films made on many parts of her anatomy. Based on the cost of "technical service," as drawn up by the Cleveland Hospital Council, the hospital received $25.50 for the production of these films. Does this sound economical? In addition, the patient had a gastro-intestinal series, no films being made. One wonders what exact value this "flat-rate diagnostic service" was to the patient. One wonders if fewer x-ray films and a more thorough clinical examination, such as was practiced under the old system, would not have been better.

In conclusion, we may note Doctor Johnson's remark that Cleveland has solved the problem of the exploitation of physicians by the hospital. We doubt if it has. We doubt it for many reasons, chiefly because the "Cleveland plan" which Doctor Johnson outlines is *not* the plan in operation in Cleveland, but also because, outside of the University Hospital group, there are *no* hospitals in Cleveland where anyone *but* a radiologist is permitted to examine the patient roentgenologically.

The hospital represents an unselfish community effort to provide the best type of care for the sick; to properly discharge this function it maintains, among other departments and facilities, adequate facilities for modern x-ray care. Everyone agrees that it must have a great interest in its x-ray investment, including its space and equipment; everyone agrees that the hospital must receive a just and fair income from its x-ray department, based upon reasonable rent for space used, and reasonable interest and depreciation on equipment purchased.

But the hospital should not expect to make a profit from professional medical procedures like the production of roentgenograms. If hospitalization insurance policies can only be sold by the inclusion of so-called hospital x-ray service, a point yet to be shown necessary, there would seem to be better ways of doing this than by the artificial division of the x-ray examination. The tendency of such division would be to decrease the quality and soundness of the medical care practiced in the hospital, which is certainly not the desire of the medical staff or the board of directors, that is, of the people who actually make the hospital what it is . . . a living institution for the care of the sick. We are

Very truly yours,

THE EXECUTIVE COMMITTEE OF THE PACIFIC ROENTGEN CLUB.

L. H. Garland, Secretary.

P. S.—Since this matter is of state-wide medical importance, a copy of this letter is being mailed to the editor of "California and Western Medicine" for publication in that journal. In addition, a short article summarizing the objections to, as well as the dangers of, the division of medical x-ray work into two artificial portions has been prepared. Copies of this article are available to all those interested.

Suite 1739, Four Fifty Sutter Street, San Francisco.

THE KETOGENIC DIET—pH DETERMINATIONS*

"The treatment of urinary infection with the ketogenic diet is a form of therapy based on producing within the body itself a chemical state which will result in the secretion of urine by the kidneys which has marked and germicidal properties. It is a known fact that bacteria will not only not grow but that they are destroyed when the acidity of the media upon which they are growing is converted into an acid media of a sufficient concentration. So it is with the urinary tract of the human body. It has been successfully demonstrated that by controlling a person's diet such a state can be produced.

"It has been known for some years that if the body is starved of carbohydrate food the normal metabolism of fats is interfered with—the fatty acids being incompletely broken down, with the result that B-oxybutyric acid, aceto acid, and acetone (collectively spoken of as ketones or ketone bodies) appear in the urine. . . .

"For a number of years the ketogenic diet, *i. e.*, a high fat and low carbohydrate diet, has been used in the treatment of certain conditions, notably epilepsy. The interesting observation was made that all cases so treated were singularly free of urinary infections. . . .

"In speaking of urinary tract infections it is necessary to determine, before instituting any type of therapy, the exact state existing in the urinary passages. Needless to say, it is important to make a complete and thorough investigation of the patient's general health. . . .

"Having secured the above information and having found a condition existing in the urinary tract, resulting from the bacterial invasion, the patient is placed upon a ketogenic diet, and the diet regulated and carefully supervised so as to produce a ketosis with a known hydrogen ion (known as pH) concentration.

"To the uninformed the expression, 'pH concentration,' may sound discouragingly scientific. At least it is an expression which may sound somewhat extraneous to the scientific vocabulary of the known scope of the nursing profession. However, this is a scentific simple understandable chemical state that can be made very elementary and easily workable. It is an essential part of the routine necessary in applying scientifically the ketogenic diet in urinary infections. I am, therefore, going to take this opportunity to explain to you the A, B, C of hydrogen ion concentration and pH control.

"Acidity and alkalinity have long been recognized as important factors in practically all branches of research and industrial work. Sugar manufacturers and refiners, electroplaters and electrotypers, paper manu-

*Excerpts from a paper by Hugh F. Dormody, M. D., Monterey, and printed in the September, 1934, issue of the "Pacific Coast Journal of Nursing."

For other comments on Ketogenic diet, see pages 336-337.